

KanCare Health Homes Provider Standards

Lead Entity (MCO) Standards

1. The KanCare health home Lead Entity must be a KanCare managed care organization contracted with the Kansas Department of Health and Environment/Division of Health Care Finance
2. Must maintain a valid certificate of authority from the Kansas Insurance Department
3. Must obtain NCQA accreditation by June 2014 for its Medicaid managed care plan

Health Home Partner Standards

1. Must enroll or be enrolled in the KanCare program and agree to comply with all KanCare program requirements
2. Must provide appropriate and timely in-person care coordination activities. Alternative communication methods in addition to in-person such as telemedicine or telephonic contacts may also be utilized if culturally appropriate and accessible for the enrollee to enhance access to services for members and families where geographic or other barriers exist
3. Must have the capacity to accompany enrollees to critical appointments, when necessary, to assist in achieving Health Action Plan goals
4. Must agree not to refuse enrollment of any eligible health home enrollee, except in cases where the safety of the enrollee or health home staff is at serious risk

Joint Standards

1. Must provide 24-hour, seven days a week availability of information and emergency consultation services to enrollees.
2. Must ensure access to timely services for enrollees, including seeing enrollees within seven days of discharge from an acute care or psychiatric inpatient stay and again within 30 days of discharge
3. Must ensure person and family-centered and integrated health action planning that coordinates and integrates all his or her clinical and non-clinical health care related needs and services
4. Must provide quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves health literacy. Examples of cultural competency include:
 - a. Interacting directly with the enrollee and his or her family by speaking their language
 - b. Recognizing and applying cultural norms when creating the Health Action Plan
 - c. Use of disability appropriate language; avoidance of inappropriate language, e.g., confined to a wheelchair, handicapped, etc.)
 - d. Recognizing the role of members in family and the decisions they can make. e.g., patriarchal, matriarchal, etc.

- e. Religious restrictions pertaining to medical care, e.g., blood transfusions, reproductive issues, etc.
- 5. Must establish a formal agreement with health service entities in order to assure appropriate access to a range of outpatient behavioral and physical health services for all of its health home enrollees. Or, the health home includes a team of co-located health professionals to provide outpatient physical and behavioral health services. For example, primary care physician, psychiatrists, nurse practitioner, social worker, etc.
- 6. Must establish a data-sharing agreement that is compliant with all federal and state laws and regulations, when necessary, with other providers
- 7. Must demonstrate their ability to perform each of the following functional requirements. This includes documentation of the processes used to perform these functions and the methods used to assure service delivery takes place in the described manner.
 - a. Coordinate and provide the six core services outlined in Section 2703 of the Affordable Care Act
 - b. Coordinate and provide access to high-quality health care services, including recovery services, informed by evidence-based clinical practice guidelines
 - c. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
 - d. Coordinate and provide access to mental health and substance abuse services.
 - e. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
 - f. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
 - g. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level
- 8. Uses an electronic health record system and/or demonstrates the capacity to use health information technology to facilitate the sharing of health information, plan(s) of care, and linking of services between the interdisciplinary team of providers, the MCO and the Health Home Partner
- 9. Is using, developing, or will provide plans to use technology to facilitate exchange of information with the individual, family care givers, and health service clinicians and providers
- 10. Demonstrate the ability to report required data for both state and federal monitoring of the program

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